

prognostic number, that is, "Take this medicine for three days and call back"; or, "Wait three days and then we'll consider a different approach."

The medical fascination with three may be built out of solid clinical experience or scientific reason. But like all traditions and "routines" it deserves reexamination to be certain that we are being cost effective and efficient. It may turn out that there is a certain amount of magic in our medical three that is as mystical as the Kaballah.

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Interaction Between Valproic Acid and Phenytoin

TO THE EDITOR: I enjoyed reading the succinct and educational "Epitomes of Progress, Neurology—Important Advances in Clinical Medicine" in the October issue. Nevertheless, in her effort to be brief, Dr Doris Trauner¹ may have left room for a potentially hazardous interpretation. She states, "Valproic acid . . . decreases phenytoin concentrations, so that blood concentrations of [this medication] should be monitored closely when used in combination with [valproic acid]." From this it would not be unreasonable for the reader to make a common assumption that if the serum concentration of the interacted drug falls below the usual "therapeutic" range, the dose should be increased. It is true that the effect of the common interaction, wherein the metabolism of drug A is stimulated by drug B, can be overcome by increasing the dose of A. This remedy *cannot* be used for the phenytoin/valproic acid interaction. While total serum phenytoin may decrease with the addition of valproic acid, the fraction of remaining phenytoin not bound to plasma protein increases. The actual concentration of this free phenytoin may unpredictably decrease,² remain constant³ or increase⁴ from pre-valproic acid levels. The paradox of this interaction has been well documented⁵ and there are recommendations that phenytoin dosage not be altered on the basis of this anticipated interaction alone.^{3,6} Unfortunately, monitoring total serum phenytoin concentrations as a measure of therapeutic success or impending toxicity will prove unreliable, not helpful and even misleading.

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Covert Diuretic Use and Anorexia Nervosa

TO THE EDITOR: In the October 1982 issue there appeared an article by Drs Spratt and Pont entitled "The Clinical Features of Covert Diuretic Use."¹ In this article the authors described the cases of two patients with covert diuretic abuse. Both of these patients, on the basis of the information provided in the article, should carry the psychiatric diagnosis anorexia nervosa. Most psychiatrists would immediately suspect that a person who took diuretics or laxatives (or both) covertly has an eating disorder. Indeed some of the other information provided in the article pointed strongly in that direction.

The baffling thing about the presentation to me is that these patients could be treated for "covert diuretic use" without addressing the real problem. Although it was a fine article and I am sure Bartter's syndrome is an entity I should know about, I am more sure that anorexia nervosa is something that the authors should know about.

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Non-Hodgkin's Lymphoma in Homosexual Men

TO THE EDITOR: As has been recently reported, the male homosexual population is at increased risk for certain tumors.¹ Recently, Ziegler and co-workers² observed another malignancy that may have an increased incidence in homosexual men. They reported four cases of a Burkitt's-like lymphoma in male homosexuals, thus adding another malignancy that may be associated with a male homosexual life-style. In the past year we have also observed two such cases of lymphoma in homosexual men:

PATIENT 1. A 29-year-old homosexual man was evaluated for increasing abdominal girth in January 1980. On physical examination an abdominal mass was found. At laparotomy, a biopsy specimen showed a Burkitt's-like lymphoma. The patient was treated with combination chemotherapy (cyclophosphamide-doxorubicin-vincristine-prednisone, or CHOP). Following an initial response complicated by the tumor lysis syndrome, the patient had progressive disease resistant to further therapy and died in March 1980.

PATIENT 2. A 27-year-old homosexual man was admitted to hospital for evaluation of an abdominal mass.